The Monthly Update of Texas Healthcare News
TEXAS HEALTH LAW NEWSBRIEF
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COURT REVERSES DEFAMATION DECISION FAVORING DOCTOR PEER REVIEW DEFENSE UPHELD

In *Lawrence Poliner vs. Texas Health Systems, d/b/a Presbyterian Hospital of Dallas*; No. 05-11235 (5th Cir. July 23, 2008) the U.S. Court of Appeals for the 5th Circuit reversed a $22.5 million jury verdict favoring a Dallas doctor who claimed he was defamed by a hospital's peer review process. The original $360 million jury award (which the judge reduced to $22.5 million) stunned many in the medical and legal communities because federal and state laws generally provide protection to peer review panels. The 5th Circuit ruled in part that participants in the peer review process have immunity if their actions were reasonably in the furtherance of quality health care. The opinion's analysis rested primarily on whether the hospital peer review committee complied with the Healthcare Quality Improvement Act (HCQIA) requirements for immunity, and whether the committee complied with the hospital's bylaws. This opinion is binding authority on federal courts in Texas, Louisiana, and Mississippi and emphasizes the importance of both hospitals and physicians serving on peer review committees to ensure the committees are structured and run in strict compliance with HCQIA requirements.

U.S. SUPREME COURT FINDS HEALTH PLAN ADMINISTRATOR'S DUAL ROLE OF BOTH EVALUATING AND PAYING CLAIMS CREATES "CONFLICT OF INTEREST"

In what could be a far reaching and significant decision for insurers, the Supreme Court of the United States recently held that an insurer serving as a plan administrator that both evaluates and pays disability/health benefits claims has a "conflict of interest" that should be weighed as a factor in determining whether there has been an abuse of discretion in reviewing the administrator's decisions. In *Metropolitan Life Insurance Co. v. Glenn*, 128 S.Ct. 2343 (June 19, 2008), an employee sought disability benefits under her employer's benefit Plan administered by Metropolitan Life. The Plan gave MetLife discretionary authority (as the administrator) to determine the validity of claims and it also provided that MetLife (as the insurer) would pay claims.

The employee sought and was awarded disability benefits and was then encouraged by MetLife to pursue Social Security disability benefits, which ultimately were paid to the Plan. But when the Social Security Administration determined the employee was permanently disabled, MetLife disagreed and denied further benefits. The District Court denied relief but the Sixth Circuit used a deferential standard of review, finding a conflict of interest in MetLife's dual role of both evaluating and paying claims and, based on a combination of the conflict and other circumstances, set aside MetLife's denial of benefits.

The Supreme Court agreed with the Sixth Circuit and held when the dual role is combined with the other factors in this case such as (1) encouraging successful recovery of Social Security benefits for MetLife's benefit, but then ignoring the Social Security Administration's findings when contrary to their own, and (2) emphasizing medical reports that supported a denial of benefits while de-emphasizing others that would lead to a contrary conclusion, were "serious concerns" that supported the decision to set aside MetLife's discretionary decision.

HEALTH INSURERS FINED $15 MILLION AND REQUIRED TO RE-INSTATE INSUREDS

Recently Blue Shield of California and Anthem Blue Cross of California were fined $15 million and told to reinstate coverage to 2,000+ former policy holders. These and other cases recently prompted California Governor Arnold Schwarzenegger to propose legislation to a put a greater burden on health insures to prove that applicants committed fraud when applying for policies before revoking coverage. These recent cases are part of a growing trend of bad faith claims arising out of health insurance claims in general, and material misrepresentation cancellations in particular, and have spiked dramatically in Texas and Oklahoma during the past two years. Life and health insurers, especially those doing business in California, Texas and Oklahoma, need to be aware of this increase because the laws in these states are extremely conducive to these types of claims. Our firm has seen a significant increase in new bad faith suits against life and health insurers in both Texas and Oklahoma during the last eighteen months. Continued media reports on big bad faith verdicts and penalties in California were immediately picked up on the electronic communication boards of plaintiffs lawyers in Texas and other jurisdictions, and will serve as more fuel for the proverbial fire for the filing similar suits in California, Texas and Oklahoma and other jurisdictions requiring evidence of an "intent to deceive" before health or life insurance policies can be cancelled due to an insured's material misrepresentation. We will continue to track these bad faith cases and report other significant developments.

HHS INCREASING INVESTIGATIONS OF ALLEGED PRIVACY VIOLATIONS

At the mid-point of 2008, Health and Human Services has already investigated nearly 10,000 alleged violations of HIPAA (Health Insurance Portability and Accountability Act). Approximately 6,700 of these complaints resulted in HHS demanding changes by the healthcare provider at issue. The increased investigations and enforcements by HHS emphasizes the need for healthcare providers to make sure they have appropriate protocols in place to comply fully with HIPAA. Equally important is ensuring staff are properly trained and strictly comply with the regulations.

TEXAS MEDICAL BOARD REDUCES BACKLOG OF APPLICANTS

In a July 14, 2008 press release, the Texas Medical Board announced that June 2008 applications for a Texas medical license averaged 44 days to process. This is a dramatic improvement because, as recently as September 2007, the average processing time for a physician application took 100 days or more. The Texas Medical Board also reported that in June, there were only 33 applicants awaiting screening. At the beginning of this year, approximately 500 applications were backlogged with a typical wait of 90 days to reach processing. Despite these significant improvements, it will be a challenge for the Texas Medical Board to maintain these improvements because of record numbers of licensing applications.

PROPOSED BILL WOULD REQUIRE DOCTORS TO DISCLOSE OWNERSHIP IN IMAGING SERVICES

Recently Senator Chuck Grassley (R–Iowa) stated his intention to submit a bill to congress that would require referring doctors to disclose their ownership in an imaging service at the time of referral. His proposal would also require physicians to disclose to Medicare beneficiaries a list of alternate providers. This bill as proposed would be broader than the current STARK referral restrictions for Medicare patients.

Senator Grassley said he hopes the bill will be passed and will limit physicians' financial incentives to order imaging services. This proposed bill is part of a continuing trend to discourage physicians from referring patients to imaging centers that they have an ownership interest in, and to encourage disclosure and alternate options if they do. Physicians in Texas should continue to be mindful of any referrals they make to any imaging or diagnostic centers in which they have an ownership interest because such referrals are likely to come under increased scrutiny. Of course, any referrals of Medicare/Medicaid patients must comply with STARK.